**MEDICAID ADMINISTRATIVE CLAIMING PROGRAM**
**STATE OF WASHINGTON – LOCAL HEALTH JURISDICTIONS**
**QUESTIONNAIRE FOR SKILLED PROFESSIONAL MEDICAL PERSONNEL**
**FOR USE BY PHYSICIANS, NURSES AND OTHER MEDICAL FIELDS**

Name _____ Job Title _____

Agency _____ Program _____

County _____ Claiming Unit _____

The following information will be used to document the status of employees as Skilled Professional Medical Personnel (SPMP) under the Medicaid Administrative Claiming program. Please respond to all of the questions. Thank you.

1. **Are you a physician licensed to practice medicine in the State of Washington?**
**___ YES ___ NO**

If YES, please provide your license number _____ and valid dates_____, sign this form and turn it in to your supervisor.

If you answered NO to Question 1, please proceed to Question 2.

2. **Have you completed an educational program in a medical field at a college or university certified by a professional medical organization? (Examples of medical fields are nursing, dietetics, audiology, and dental hygiene.) ___YES ___NO**

If you answered NO, you do not need to fill out the remainder of this questionnaire. Please go the last page, sign this form and turn it in to your supervisor.

**If YES, did your educational program last at least two years? ___Yes ___ No**

If YES, please list the highest academic degree you received in a medical field, the subject in which it was received, and the name of the college/university where it was received, and then proceed to Question 3.

Academic Degree _____

Field/Subject Area _____

College or University _____

If you answered NO, you do not need to fill out the remainder of this questionnaire. Please go the last page, sign this form and turn it in to your supervisor.

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3. **Did your educational program lead to licensure by a National or State medical licensure organization?** (An example is a State license as a registered nurse.) **___YES ___NO**

If YES, please provide license type, number, valid dates, and licensing organization. Then sign this form and turn it in to your supervisor.

License Type _____ License Number _____

Valid Dates _____

Licensing Organization _____

If you answered NO to this question, please proceed to Question 4.

4. **Did your educational program lead to certification or registration by a medical or health-related National certifying organization (such as the American Speech and Hearing Association), or State of Washington certifying organization? ___YES ___NO**

If YES, please provide certification/registration type and number, valid dates, and the name of the certifying organization. Then please sign this form and turn it in.

Certificate/Registration Type _____

Certificate/Registration Number _____ Valid Dates _____

Certifying/Registry Organization_____

_____ _____
Employee Signature Date